MIC METRO INFUSION CENTER

Romiplostim (NPlate)

Name: _____
DOB:_____
Diagnosis/Code: _____/_____

Dose calculation: Mcg/Kg dosing **Wt used for dosing:_____kg**

☐ Dose should be based on current day of injection weight and thus changes each visit (can be rounded to nearest vial size available at the visit)

☐ Use weight on order unless weight changes more than 10%

Dosing Guidelines/Parameters: ***Provider must select hold parameters that will trigger a call from the Infusion Staff***

☐ CBC will be done prior to each dose

☐ Dosing based on most recent platelet count (Review of labs is the responsibility of the referring provider office and must be sent with the clearance form attached to this order to guide treatment).

☐ Hold platelet count greater than 400,000 OR If the platelet count is greater than 200,000 for 2 consecutive weeks, reduce the dose by 1mcg/kg each week the level is above 200,000

Treatment Orders:

DRUG	DOSE	ROUTE	DAYS TO BE GIVEN
☐ Romiplostim (NPlate) **starting dose**	1mcg/kg= _____mcg	SQ	x1 dose then based on platelet count**
☐ Romiplostim (NPlate) Current dose patient is on (if not on 1mcg/kg) at time of transition to Metro Infusion Center	_____mcg/kg= _____mcg	SQ	X 1 dose then based on platelet count**
☐ Romiplostim (NPlate) Fixed dose- no titration up will occur	_____mcg/kg= _____mcg	SQ	Every _____ week(s)*

**The NPlate clearance form should accompany the labs from the providers office

NOTE: Dose changes may require new insurance authorizations.

☐ Ok to give current dose level until new authorization obtained

Date of intended first treatment at Metro Infusion Center:_____

Subsequent treatment may be given +/- 2 days or as otherwise specified:_____

This order is good for 1 year from the date ordered

Other:

Call referring provider for:
Hypertension

Date:

Referring Provider:_____ _____ Phone# _____
SIGNATURE REQUIRED PRINTED NAME REQUIRED

Office Contact name/number:_____/_____

All information in this order is strictly confidential and will become part of the patient's medical record. Contact us with questions at (877)448-3627. Send completed form and all documentation to confidential email: MICreferral@metroinfusioncenter.comor fax to (866)507-1164

Created 2/22/26

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Romiplostim (NPlate)Clearance form

To be completed by the office prior to EACH dose; accompanied by the CBC and signed by the provider to guide dosing based on platelet count as per PI

☐ CBC has been reviewed

Dosing instructions

☐ platelet count is < 50 × 109/L, increase the dose to _____mcg SQ x 1
(This serves as the current order. This clearance form must be sent for guidance for next treatment)

☐ platelet count is > 200 × 109/L and ≤ 400 × 109/L for 2 consecutive weeks, reduce the dose to _____mcg SQ x 1 (give this dose at upcoming visit)
(This serves as the current order. This clearance form must be sent for guidance for next treatment)

☐ Based on labs; no dose change, keep dose _____mcg SQ
(previous order is still active and should be used for dosing)

☐ Based on current labs; patient will not get treatment.
Follow up noted below in "additional comments"

NOTE: Dose increase may require new insurance authorizations.

☐ **Ok to give current dose level until new authorization obtained**

Any additional comments:

Signature of provider:_____/Date:_____

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